Statement of Len M. Nichols, Ph.D.

On

HB1148

Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments

March 3, 2022

My name is Len M. Nichols. I am a health economist, non-resident Fellow of the Urban Institute's Health Policy Center, Professor Emeritus at George Mason University, advisor to the Virginia Center for Health Innovation, and President of NS Ideas, LLC, a health policy research and consulting firm. I was a Board Member of the National Committee on Quality Assurance from 2006-2021, an early advisor to the Center for Medicare and Medicaid Innovation, former advisor to the Patient Centered Primary Care Coalition, and member of the Physician-Focused Payment Model Technical Advisory Panel (to the Secretary of HHS) from 2015-2019. I have studied, published, spoken, testified, and taught about ways to improve the efficiency and equity of our health care system for over 30 years, beginning when I was a professor at Wellesley College and then as a Senior Advisor for Health Policy at the Office of Management and Budget during the Clinton Administration. My research spans insurance market reforms, provider payment and delivery system reforms, formal evaluations of patient centered medical home programs (including one organized by CareFirst in the Mid-Atlantic), ways to use payment reform to promote racial and ethnic health equity, and most recently, ways to finance and incentivize collaborative and sustainable investments in social determinants of health. My statement today represents my views alone, and not necessarily that of any organization I am now or have been affiliated with in the past.

My career has allowed me to see our health care system achieve notable coverage (SCHIP, ACA) and treatment successes (e.g., outpatient surgeries, diabetes and blood pressure management, etc.,), but I have also been an intimate witness as health spending rose from 12% of GDP in the early 1990s to almost 19% today. I also note that our life expectancy and general health outcomes performance fall far short of competitor countries who also manage to spend far less than we do. In short, we get less health value per dollar than most other comparable countries. I have seen more "promising" cost-containment strategies fail than I can list (or even remember). Most health economists would agree and I certainly believe this is largely because, notwithstanding all our tinkering with relative fee schedules, conversion factors, DRGs, prior authorizations, high deductibles, narrow networks and pay for performance measurement details, we have largely failed to get health service provider incentives right. The attributed Churchill quote does come to mind: "You can always count on the Americans to do the right thing, after they've tried everything else."

The main thing we have not tried with sufficient vigor is incentivizing providers to lower costs, that is to say, to use payment policy to align provider interest with the social interest in *both* quality care and efficient resource use.

Historically, it's not hard to understand our reluctance to incentivize providers to lower cost. Wouldn't their incentives then be to shortchange us, not go the extra mile to help us recover? A hundred years ago, when treatments in practice were as likely to hurt you as help you, it made sense to encourage volume and experimentation through fee for service medicine, which also has the American virtue of rewarding doctors who "work harder."

However, multiple trillions of public and private dollars later, we now see clearly that fee for service medicine encourages volume far more than it is associated with higher quality, and in fact today is more associated with unnecessary or even harmful care than is care delivered through properly incentivized provider arrangements, like capitation or two-sided risk more broadly.

Two-sided risk and capitation arrangements are spreading now in the US for at least four reasons.

First, they are the only payment and accountability tools capable of aligning provider, payer, and patient interests simultaneously, and recognition of this fact is spreading.

Second, the quality measurement revolution has raised payer and patient confidence that the distinct minority of less scrupulous providers who might be tempted to shirk appropriate care will in fact be penalized for that, and will clearly be better off "doing the right thing the first time," which is the point.

Third, with the experimentation in value based or accountable payment models that began in the private sector before the ACA and which has exploded since the various ACOs and other models promoted by the ACA, important lessons in how to structure risk-sharing arrangements to be mutually advantageous have been learned and that knowledge has spread like public goods should.

Fourth, and arguably most importantly, persistent inequities in health opportunities that were revealed quite savagely both by the COVID-19 pandemic and George Floyd's videotaped murder, has convinced a growing number of health organization executives, policy makers, and community based social service providers that considerable health care savings and health equity improvements could be achieved if we can find ways to invest more in social determinants of health. Fee for service medicine rules, and even most current managed care contracts, prohibit health care organizations from investing broadly in the health-related social needs of their patients, let alone of community members at large. More open-ended two-sided risk and capitation arrangements that focus on outcomes and not process, by contrast, would enable more health care organizations to shift focus and resources onto upstream social factors affecting

patients' health. We need federal and state policy changes to enable still more of this sort of thing, but a necessary condition in every state is that these risk-sharing contract forms be legal.

Which is where this important proposed legislation comes in. Since before I began my career, Maryland has long been known as a leader in using state policy to balance competing demands of more access to quality care and affordability. Your Health Service Cost Review Commission has been uniquely effective in many respects. Which is why it is surprising to outsiders that the most modern health and social value enhancing tools of two-sided risk sharing and capitation are not generally permitted between insurers and providers in Maryland at present.

I can imagine some small independent clinicians might worry in the abstract that they could be forced to accept more risk than they could handle with their smaller patient panels and underdeveloped care management infrastructure. Which is why two provisions in the proposed law are particularly important. One makes clear that any risk sharing contract must be voluntary, so providers always have the right to refuse the new payment arrangement. And the other makes clear the fee for service fee schedule cannot be arbitrarily lowered to pressure practices to agree to an agreement they are afraid of. With these guardrails protecting small practices, I can wholeheartedly support the goals and mechanisms of this legislation that would enable Maryland's health care system to use the most effective incentives we have yet devised to improve value per dollar while balancing access, quality and cost.

I hope this statement is useful to your deliberations and I would be glad to answer any questions it or other ideas presented to you may have engendered.

Respectfully,

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